Serving the People of California

Employment Development Department

CLAIM FOR REFUND OF EXCESS CALIFORNIA STATE DISABILITY INSURANCE DEDUCTIONS

DO NOT FILE THIS CLAIM FOR REFUND UNLESS YOU ARE EXEMPT FROM CALIFORNIA STATE INCOME TAX. IF HUSBAND AND WIFE BOTH QUALIFY, COMPLETE A SEPARATE FORM FOR EACH SPOUSE.

1. **PLEASE TYPE OR PRINT**	First Name and Initial	Last Name	Social Security Number
	Present Home Address (Number and Street, including apartment number, or rural route)		For Tax Year:
	City, Town or Post Office, State and ZIP Code		Date Filed

Complete schedule below if you worked for two or more employers and deductions for California State Disability Insurance (SDI) exceeded the amount shown in Column 7(D) below.

LINE	WAGE SUMMARY EMPLOYERS BUSINESS NAME AND CITY AS SHOWN ON W-2 FORM (List in Alphabetical Order)	DATES EMPLOYED DURING CALENDAR YEAR 19___		WAGES PAID TO YOU DURING 19___ DO NOT SHOW MORE THAN THE AMOUNT SHOWN IN COLUMN 7(C) FOR ANY ONE EMPLOYER		ACTUAL DEDUCTION FOR SDI NOT TO EXCEED PERCENTAGE RATE SHOWN IN COLUMN 7(B) OF WAGES SHOWN IN COLUMN (C). DO NOT LIST FICA DEDUCTIONS	
	COLUMN (A)	COLUMN (B)		COLUMN (C)		COLUMN (D)	
	NAME LOCATION	FROM (MONTH)	TO (MONTH)	DOLLARS	CENTS	DOLLARS	CENTS
2.							
	3. Total DI taxable wages paid						
	4. Total ***actual*** deductions for SDI						
	5. Enter amount shown in Column 7(D) for tax year						
	6. Refund claimed (line 4 less line 5)						

7. **TABLE OF MAXIMUM WAGES AND REQUIRED CONTRIBUTIONS**

(A) Tax Year	(B) Percentage Rate	(C) Maximum Wages	(D) Maximum Contributions
1995	**1.0%**	**31,767**	**317.67**
1996	**0.8%**	**31,767**	**254.14**
1997	**0.5%**	**31,767**	**158.84**
1998	**0.5%**	**31,767**	**158.84**

8. ***I hereby declare that I am exempt from California State Income Tax and therefore am filing this claim directly with the Employment Development Department.***

I further declare under penalty of perjury that the statement of wages paid to me and contributions deducted, as shown hereon, are true and correct to the best of my knowledge and belief.

SIGNATURE _____ DATE _____

INSTRUCTIONS
CLAIM FOR REFUND OF EXCESS CALIFORNIA STATE DISABILITY INSURANCE DEDUCTIONS

CLAIM MUST BE BASED ON CALENDAR YEAR WAGES
A valid SDI refund claim filed directly with the Employment Development Department on this form must meet ***ALL*** the following conditions:

1. Claimant worked for two or more employers subject to withhold California SDI.
2. Deductions for California SDI were made from calendar year wages.
3. Such deductions exceed the statutory limits.
4. Claimant declares by signature to exemption from California State Income Tax.

WHERE TO FILE CLAIM:
The Employment Development Department, P.O. Box 826880, MIC 5, Sacramento CA 94280-0001.

WHEN TO FILE CLAIM:
Claims for credit or refund of California State Disability Insurance overpayment must be filed within three years after the end of the calendar year in which the excess deductions were made. The claim must be based on the calendar year in which the wages were received.

AMENDED CLAIMS:
Amended claims must be so marked (if not, they will be returned to claimant) and forwarded to the Employment Development Department, P.O. Box 826880, MIC 5, Sacramento CA 94280-0001.

INFORMATION FOR COMPLETING WAGE SUMMARY SCHEDULE:

a. Disability insurance deductions are shown on W-2's, employer's statements, check stubs.

b. Most federal, state and local government agencies are not required to deduct California Disability Insurance. Do not include these wages in your claim unless disability insurance deductions were ***actually*** made.

c. ***Do not*** include in your claim:

   (1) Deductions made from your wages for Federal Old Age, Survivors and Disability Insurance (FICA), or federal and state income tax withheld from your wages.

   (2) Deductions made from wages earned in states other than California unless such wages were reported to the State of California.

   (3) Seamen's wages that come under the jurisdiction of States other than California.

d. Self-employed Persons – Enter in Column (A) "Covered under California Unemployment Insurance Code Section 708 or 708.5" and complete Column (B). Failure to enter this information will result in rejection of your claim on initial review.

Instructions for completing DE 1964:

1. Enter all information requested in grid 1.
2. Enter employer information –
   Column (A) – All employers and location of job sites.
   Column (B) – The calendar year dates employed by employer in Column (A).
   Column (C) – Wages up to $ _____ paid to you by individual Column (A) employers.
   Column (D) – Enter actual amount of SDI withheld. Do not exceed _____ % of wages in Column (C).
3. Enter total wages paid.
4. Enter total of all SDI deductions withheld by each employer in Column (D). This amount must be verified by attached W-2 forms showing SDI amounts withheld or a statement from the employer indicating the amount of SDI withheld.
5. Enter maximum contribution for tax year (see Column 7(D)).
6. Enter amount of refund claimed (line 4 less line 5).
7. Table of Maximum Wages and Required Contributions (reference table only).
8. Read and sign this declaration which states you are exempt from California State Income Tax. Without your signature, your claim will be rejected.

ASSISTANCE:
If you need assistance in completing this claim, contact the State Disability Insurance Refund Unit office of the Employment Development Department, P.O. Box 826880, MIC 5, Sacramento CA 94280-0001, (916) 654-8333.